

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/09/2011	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME & REHABILITATIVE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 231 N JACKSON ST OAKLAND CITY, IN 47660			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a post survey revisit [PSR] to the Recertification and State Licensure Survey, completed on 10/31/11. This visit included the PSR to the investigation of complaint number IN00098540, completed on 10/31/11.</p> <p>This visit was in conjunction with the investigation of Complaint number IN00100128.</p> <p>Complaint number: IN00098540 Corrected</p> <p>Survey dates: December 8, 9, 2011</p> <p>Facility number: 000327 Provider number: 155561 AIM number: 100273920</p> <p>Survey team: Amy Wininger, RN TC 12/8/11 Diane Hancock, RN Vickie Ellis, RN Barbara Fowler, RN</p> <p>Census bed type: SNF/NF 82 Total 82</p> <p>Census payor type: Medicare 8 Medicaid 45 Other 29 Total 82</p> <p>Sample: 10</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	<p>Continued From page 1</p> <p>Good Samaritan Home and Rehabilitation Center was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the PSR to the recertification and state licensure survey and the PSR to complaint number IN00098540.</p> <p>Quality review completed 12/14/11 Cathy Emswiller RN</p>			{F 000}			